

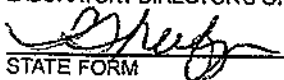
PRINTED: 09/13/2013  
FORM APPROVED

## Division of Health Care Facilities

|   |  |   |  |                          |
|---|--|---|--|--------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>TN7502  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br>B. WING: _____                            | (X3) DATE SURVEY<br>COMPLETED<br><br>09/11/2013  |                          |
| NAME OF PROVIDER OR SUPPLIER<br><br>BOULEVARD TERRACE REHABILITATION AND NURSING HOME |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1530 MIDDLE TENNESSEE BLVD<br>MURFREESBORO, TN 37130 |  |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
| N 002   | 1200-8-6 No Deficiencies<br><br>During the annual Licensure survey conducted at<br>Boulevard Terrace Rehabilitation and Nursing<br>Home on September 9 - 11, 2013, no deficiencies<br>were cited under 1200 - 8 - 6, Standards for<br>Nursing Homes. | N 002   |  |                          |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



STATE FORM

6899

VOZY11

TITLE



(X6) DATE

9/24/13

If continuation sheet 1 of 1